

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-043581**

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1655

FILED DEC 5 1963

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Cook</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Springfield</u>		c. CITY OR TOWN <u>Theodosia</u>	
c. FULL NAME OF (If NOT a hospital, give location) <u>St. Johns Hosp</u>		d. STREET ADDRESS (If outside, give location) <u>1 mile off end Highway</u>	

3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Ellis</u> Last <u>Schofield</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>24</u> Year <u>1963</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-13-1876</u>	9. AGE (last birthday) <u>87</u>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN</u>		11. BIRTHPLACE (City and state or country) <u>Pontiac Mo.</u>	
13a. FATHER'S NAME <u>Ellis Schofield</u>		13b. MOTHER'S MAIDEN NAME <u>Laura Luckenbaugh</u>		14. NAME OF HUSBAND OR WIFE <u>Kora Henderson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PROBABLE CORONARY OCCLUSION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
DUE TO (b) <u>HYPERTENSIVE CARDIOVASC. DISEASE</u>		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>INTERTROCHANTERIC FRACTURE, LT. FEMUR</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>FALL AT HOME</u>	
20c. TIME OF INJURY Hour <u>11</u> a.m. <u>23</u> p.m.	Month, Day, Year <u>11-23-63</u>		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>HOME</u>	20f. CITY, TOWN, OR LOCATION <u>THEODOSIA</u>	STATE <u>MO.</u>
21. I attended the deceased from <u>Nov. 24, 63</u> to <u>SAME</u> and last saw him alive on <u>SAME</u> Death occurred at <u>9:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <u>James E. Johnson, M.D.</u>		(Degree or title)		22b. ADDRESS <u>307 Prof. Bld. Springfield, Mo.</u>	22c. DATE SIGNED <u>11-29-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11-28-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lu Tie</u>		23d. LOCATION (City, town, or county) (State) <u>Theodosia Mo.</u>	
24. FUNERAL DIRECTOR <u>Chinkingbeard Gainesville</u>		ADDRESS <u>12-2-63</u>		25. DATE RECD. BY LOCAL REG. <u>12-2-63</u>	
26. REGISTRAR'S SIGNATURE <u>Bernie Mallett</u>					

(Licensed Embelmer's Statement on Reverse Side)

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

182730-1011

11-24-63

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*John R. Carey*

Licensed Embalmer No.

*4885*

P. O. Address

*Camdenville Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.